FBU's Written Opening Submissions for Module 3 of Phase 2

1) The FBU and the firefighters and Control staff we represent remain:
   a) humbled by the suffering of the deceased and the bereaved, survivors and relatives of the deceased (BSRs) as a result of the Grenfell Tower disaster; and
   b) committed to a full and open inquiry.

2) These submissions focus on the lifts in Grenfell Tower. This is not to detract from the importance of the other matters being investigated in all 3 Topics under Module 3 (as to which please see paragraphs 39 &ff below) but to assist the Panel as best we can to address the question why the lifts did not work as intended on the night of the fire on 14 June 2017.

3) **Outline of the FBU's submission on the lifts:** (the number "§..." in round brackets refers to the paragraph numbers in this submission covering the issue)
   a) The inoperable fire control switch (the "FC switch") impeded firefighting operations and exposed occupants to danger (§4)
   b) The lifts were filled with smoke and unuseable after 01:40 (§5)
   c) The defective condition of the lifts should have been, but was not, reported by the lift engineers before the fire (§§6-12).
   d) Mr Howkins' assumption, that lift engineers tested the FC switch before the fire and did not note any faults, is unreliable (§13).8iu
   e) It all comes down to the witness evidence of Bureau Veritas and PDERS (§14).
   f) The evidence of inspections by Bureau Veritas and PDERS points the other way (§§15-25).
   g) They were not firefighter lifts, so there was no triangular key which would have lessened the chances of a firefighter having a key with the incorrect dimensions (§26).

h) It is not known which drop release key was used by firefighters on the night, there is no criticism of firefighters sourcing their own drop keys, and firefighters tried repeatedly to operate the FC switch as soon as they got into the tower and thereby repeatedly manipulated it (§§27-28).

i) Firefighter lifts would have made a difference (§29).

j) The firefighters were unable to take control of the lifts because the FC switch was blocked with builders' debris (§§30-34).

k) The FC switch came to be blocked with builders' debris because it was not looked after properly during the main refurbishment works or replaced thereafter (§35).

l) The lifts were in poor condition and not working properly before the fire (§§36-38).

4) **The inoperable FC switch impeded firefighting operations and exposed occupants to danger**

a) Dr Lane advised at §19.5.72 of Section 19 of her Phase 1 report of 24 October 2018 {BLAS0000019_0025} that: "… all other operations by the LFB within the 23 storeys were required to be by means of walking up and down the stair only (including carrying their equipment). This would have increased the time required by the firefighters wearing breathing apparatus to reach the upper levels and reduce the time available to them to undertake rescue operations. This was exacerbated by the very low position of the Bridgehead.".

b) And at L6.1.3 of {BLAS0000033} "As the lifts were not specified to meet the standard of a fire-fighting lift, they could not be used for evacuation. Firefighters would not use a "fire lift" for human transport due to its lower safety standard".

c) Mr McGuirk advised at §213 of his report of … {SMC00000046_0078} "… I would further add to the Chairman's list of difficulties the fact that there was no fire lift available to the responding crews. This is significant, because there was only standard duration breathing apparatus equipment available to the first responding crews, which, without the ability to get to upper floors quickly via the lift, would have materially limited the height to which firefighters could physically travel to initiate or to assist with evacuation. …"

d) Occupants should not have been but were able to use the north lift with fatal consequences (see §6(b) below).

5) **Perspective - the lobbies were heavily smoke logged by 01:40**

a) Working firefighter lifts would have been of great assistance to the firefighters in the early stages of the emergency response until about 01:40 on the night of the fire, By then the lobbies on nearly all floors (i.e. all except floors 7, 9 and 13) between floor 5 and floor 23 were either significantly or heavily smoke logged [Chairman's Phase 1 report, Ch.25, §25.10]. Any use of the lifts to assist with rescue or evacuation would have been severely limited after that time in any event. The LFB could not use the lifts for evacuation. Even after the stay put advice was formally revoked in the control room at about 02:35 [Phase 1 report, Part III, Chapter 29, §29.94], no attempt was made to use the lifts, e.g. the control room advised the caller (either Genet Shawo or Rabia Yahya) in Flat 153 on floor 18 at 02:48 not to use the lift when trying to evacuate {LFB00000384}: "*...Make your way down, don't use the lift, use the stairwells, okay, but you need to put wet blankets and that around your mouth and the kids as well, ...*".

b) **The lifts were filled with smoke and unuseable after 01:26 to 01:37**

i) **Use of the South lift until 01:37 -** Immediately before the fire the south lift [otherwise referred to as the left lift / H090 / 'the one with CCTV' (herein the "south lift")] was used normally by residents including the Neda family, until about 01:01 [please see the 'FBU's Chronology of Lift Use' attached hereto]. From 01:01, and for just over half an hour, firefighters made some limited use of the south lift until BA Team 5 were forced to exit when it stopped unexpectedly at around the 8th floor level and filled with thick black smoke at about 01:37. There is no evidence the south lift was used again on the night.

ii) **Use of the North lift until 01:26 with fatal consequences -** From 01:06 the north lift [otherwise referred to as the right lift / H091 (herein the "north lift")] was used by 9 residents to self-evacuate until 01:26 when Rhea Rojo and Nadia Jafari fled the smoke filled lift car when the doors opened on the ground floor [the 'FBU's Chronology of Lift Use']. There is no evidence the north lift was used again on the night. CM Gallagher called the north lift to the ground floor at about 01:34, but when the doors opened, thick black smoke poured out of the lift car and shaft. CM Gallagher determined it would be impossible to use. The bodies of Mohamednur Tuccu, Khadija Khalloufi and Ali Yawar Jafari were recovered in the lift lobby at floor 10. The Chairman has found that these people may have been in the lift when

it left Floor 11 and then got out of the lift when it reached Floor 10 (Vol.2, §10.224). The late Mr Jafari almost certainly was in the lift. None of the residents should have been able to use either lift after the firefighters had tried to take control by operating the FC switch at 01:01. The inoperable FC switch thus probably had fatal consequences.

6) **The defective condition of the lifts should have been, but was not, reported by lift engineers before the fire**
   a) The fire alarm recall function was not working before the fire;
   b) The mechanism of the FC switch was seized and damaged/deformed
   c) The incoming earth wire to the main isolator of the north lift was extended, wrapped with insulation tape and concealed
   d) The temporary FC switch on floor 2 was still in place, albeit disconnected; whereas it should have been removed.

7) **The fire alarm recall function** was not working before the fire. Mr Howkins summarized a BRE report (RHO§453) which concluded that the fire alarm recall was disconnected by cutting the physical wiring connection with straight cut ends so there was no connection between the lift controller and the smoke detection system (RHO§451 and §453). "*At this stage, there is insufficient information for me to comment on when the fire alarm recall was disconnected, why it was disconnected, and who may have disconnected the system. I can say, however, that it was disconnected by cutting the physical wiring connection….*".

8) After the fire, both lift cars were found stuck just above the floor 10 [paragraph 450 of Mr Howkins' report of September 2020 {RH000000003_0180} ("RHO§450")]. Lift inspectors on their 'site visit 2' on 18 April 2018 were unable to determine why both lift cars had stopped 75mm to 100mm above the 10th floor {RH000000004_0130}.

9) These inspectors noted other defects suggesting a lack of pre-fire examination by the lift service company [site investigation report of August 2018 for Operation Northleigh {RH000000004_0108 and _0130}]:

a) "… The **(ground floor) fireman's switch** was difficult to operate. The faceplate was removed to determine the reason for failing to operate the switch. We discovered that the mechanism was seized and damaged/deformed. … As the mechanism on the fireman's switch on the ground floor was defective then we can assume this had not been examined by the lift service company at regular intervals. …

b) The incoming **earth wire** to the main isolator of lift H091 was extended and wrapped with insulation tape before being concealed inside the conduit. This is poor/bad practice. The earth wire should have been replaced during the modernisation works. …

c) As the **fireman's switch on the 2nd floor** (walkway) was not connected to the controllers we can only assume that it was never tested at regular intervals. … "

10) As to the **FC switch on floor 2**, Mr Howkins concluded at §146, §540-1, & §359 {RHO00000003} that during the refurbishment works:

a) The fire control switch ("FC switch") had been disconnected from the ground floor,

b) a temporary FC switch had been installed at walkway level on floor 2,

c) this temporary FC switch had been disconnected by August 2016,

d) the ground floor FC switch had been reconnected from about August 2016,

e) the disconnected temporary FC switch had been left in place on floor 2.

f) It should have been removed.

11) The FBU submits that any competent lift engineer who inspected the lifts and tested their firefighting features in the months leading up to the fire, could reasonably be expected to have noticed the above defects and to have reported the need:

a) to reconnect the fire alarm recall;

b) to clean and repair or replace the ground floor fireman's / fire control switch (hereafter the "FC switch");

c) to replace the earth wire,

d) to disconnect and remove the disused FC switch on the 2nd floor.

12) None of them did. The Inquiry may conclude that was because they were not asked or encouraged to do so by their supervisors until after the fire.

13) **Mr Howkins' assumption, that lift engineers tested the FC switch before the fire and did not note any faults, is unreliable:**

a) **The assumption**: Mr Howkins has reported at §487.2 of his {RHO00000003_0192} "*…That, **assuming** that PDERS were checking the operation of the fire control switch and associated systems each month, it does not appear that any other potential maintenance deficiencies would have affected the operability of the fire control switch or the lifts themselves on the night of the fire…".* He further reports at §599.3: "*The witness evidence of engineers from Bureau Veritas and PDERS set out earlier in my report is that they tested the fire control switch before the fire and did not identify any faults.*

599.3 .1. Isiaka Lasisi from Bureau Veritas tested the switch on 2 November 2016.

599.3.2. Michael Arnold from Bureau Veritas tested the lifts on 10 April 2017. I am awaiting a witness statement from him but the inspection reports from the testing do not note any faults with the fire control switch.

599.3.3. Mark Wallis from PDERS tested the lifts, including the fire control switch on 9 May 2017 and did not note any faults. …"

b) Mr Howkins acknowledges at §602 that it is the function of the Panel to make findings of fact {RHO00000003_0224}. The FBU asks the Inquiry to investigate whether Mr Howkins' assumption can be properly made.

14) **It all comes down to the witness evidence of Bureau Veritas and PDERS:**

a) Mr Howkins found no evidence of regular or any testing of the FC switch by the TMO's lift engineers [see RHO§462], by the Gerald Honey Partnership (GHP) [see RHO§504], Apex [see RHO§360] or Calfordseaden [see RHO§369), even though they were all supposed to do so.

b) Likewise Dr Lane has reported, see e.g. §12.2.29 of Section 12 of Chapter 8 of her Module 3 report {BLARP20000027} "… *In Chapter 7 I have presented the evidence which shows there are no written records available to me at this time, to demonstrate that the fire brigade key switch, which is located outside the lift car, was ever manually operated in a routine inspection."*

c) So it all comes down to the witness statements filed on behalf of Bureau Veritas and PDERS. These are all self-serving because both companies were obliged to inspect the FC switch under the terms of the 2017 procedure (for Bureau Veritas) and the contract with the TMO (for PDERS).

15) **The evidence of inspections by PDERS and Bureau Veritas points the other way -** As to Mr Howkins's observations at RHO§599.3, the FBU asks the Inquiry to consider

a) whether there is any reliable evidence to support the proposition that the engineers from Bureau Veritas and PDERS tested the FC switch before the fire and did not identify any faults; or

b) whether the reliable evidence points the other way, to the conclusion that they did not test the FC switch before the fire.

16) **As to inspections by Bureau Veritas:**

a) At §13 of his Witness Statement of 8 November 2019 {BVL00000006} Kyle Veitch references the Bureau Veritas inspection procedures:

i) The old procedure of 2014 {BVL00000013}, covering 2 pages, made no mention of testing or checking the FC switch. The 2014 procedure was in force until February 2017, and

ii) The new procedure of 2017 {BVL00000011} mentioned fire control features briefly under "Key points" on p.4: - *"…• Take into account any additional control features i.e. Fire fighting, Fire recall, Vandal resistant…."*.

b) The 2017 procedure was in force from February 2017, but there is no evidence from Bureau Veritas witnesses or otherwise of any training or instruction to give effect to it during inspections before the fire. Even if Mr Arnold had received any such training before 10 April 2017, which he does not aver, the new procedure (of February 2017) covering 19 pages did not mention the Regulatory Reform (Fire Safety) Order 2005 (the "FSO") under "Applicable legislation" on p.2, nor did it specify any check or testing of the FC Switch in the "Method Statement" on p.3 or elsewhere. This suggests there was no requirement on the Bureau Veritas engineers to inspect these fire controls and requires explanation. Moreover there is no evidence the "fire recall" feature was

inspected or tested on 10 April 2017, as would have been expected if the new 2017 procedure had been applied (see §15(a)(ii) above).

17) The Inquiry may conclude the FC switch was not inspected on any of the three most recent pre-fire Bureau Veritas inspections of 2 June 2016, 2 November 2016, or 10 April 2017:

a) As to the inspection of 2 June 2016: the Bureau Veritas 'Reports of Thorough Examination of Lifting Equipment' for the lifts in Grenfell Tower were reported on 3 June 2016 [{MET00035852} & {MET00035853}].

i) The 2014 procedure applied to this inspection.
ii) There is no mention in the reports of checking the FC switch or the fire recall function.
iii) It is not known who carried out this inspection, which was signed by Mr Veitch who has explained at §31 of his statement that he did not attend the inspections of the lifts at Grenfell Tower or review these reports before being asked to do so as part of this Inquiry.
iv) There is no evidence the FC switch was inspected on this occasion.

b) As to the inspection of 2 November 2016: Isiaka Lasisi filed 'Reports of Thorough Examination of Lifting Equipment' for both lifts in Grenfell Tower on 2 November 2016 [{MET00036572} & {BVL00000016}].

i) In his witness statement of 8 November 2019 {BVL00000015} Mr Lasisi says at §2 that he joined Bureau Veritas in 2008, and at §3 that "... *When I first started, we followed procedure IP/LIF001: Thorough Examination of Traction Passenger, Passenger / Goods Lift, Goods and Service Lifts* ...". This is the 2014 procedure {BVL00000013}. There is anyway no evidence that the procedure in force in 2008 included any provision to inspect the FC switch. As set out above, the 2014 procedure did not.
ii) At §6 &ff Mr Lasisi describes his tests on the safety switches in the present tense, giving rise to the inference that he is there describing how he was testing them when he gave his statement on 8 November 2019, i.e. after the fire and with the benefit of hindsight.

iii) He does not describe any training on the 2017 procedure nor any instruction to implement it before his inspection on 2 November 2016.

iv) At §13 he said the Bureau Veritas procedure for carrying out 'Thorough Examinations' is "...*on my tablet if I need to refer to it* ..." and that he records his findings in his notebook. It can be inferred that would be the 2014 procedure. It cannot be properly inferred this would be the 2017 procedure since the inspection was in 2016.

v) At §11 he says he does not recall the inspection itself and at §17 & §22 he says he "...*would have*..." checked the FC switch, but he does not say he actually did so.

vi) He says nothing about the fire recall function or the other defects listed above in either the reports or his statement.

c) As to the inspection of 10 April 2017, at §32 of his statement {BVL00000006}, Mr Veitch says Michael Arnold carried out the inspection on 10 April 2017. There was no statement from Mr Arnold when Mr Howkins reported, and he reserved his opinion accordingly (RHO§498). Mr Arnold had by then filed his "Reports of Thorough Examination of Lifting Equipment" dated 12 April 2017 for those inspections {BVL00000008}:

i) There is no mention therein of the new inspection procedure of 2017 or of the FC switch.

ii) There is no record of any inspection of the FC switch or the other defects listed above in §8;

iii) He recorded nothing about the fire recall function, even though:

(1) it was cut (RHO§453), and

(2) the 2017 procedure {BVL00000001} mentioned this function briefly under "Key points" on p.4.

iv) Based on this report alone, it seems unlikely the FC switch was inspected on this occasion either.

18) Mr Arnold has since provided a statement of 27 November 2020 {BVL00000017} asserting that he activated the ground floor FC switch and found no defects. However, several passages of this statement raise doubts about whether he did in fact check the FC switch:

a) At §1, he describes receiving initial training with Bureau Veritas when he joined in 2013, but does not describe any training on the new procedure of Febuary 2017 {BVL00000011} before his visit to Grenfell Tower on 10 April 2017 or at all;
b) At §4, he references both the 2014 and the 2017 procedures for inspecting lifts, respectively {BVL00000013} and {BVL00000011}, but does not say which one he applied on 10 April 2017;
c) At §5, states "... I was not advised as to whether the lifts were "firefighting lifts..." before his visit on 10 April 2017;
d) At §6(a), states he inspected the lifts "...in accordance with the procedures..." but does not state which one he applied, although his description of what his inspection involved reflected the 2014 procedure (not the 2017 one);
e) Further at §6(a) &(b) he states he activated the ground floor FC switch, using an express drop release key provided by Bureau Veritas adding "*The lift was then observed, to ensure that the lift responded correctly to the activation of the fire control switch, by going into fire control mode. Fire control mode caused the lift doors to close and the lift to return to the main exit floor, which in this case was the groundifloor. The lift was then further observed, to ensure that it remained on the ground floor with the lift doors open, and did not respond to any other calls made.*" But this describes no check that the lifts could not be called from any other floor in "fire control mode" and refers to "the lift" (in the singular), making no mention of checking both lifts: they both should have returned to the ground floor and then not responded to other calls.
f) At §6(c), he said "...*The outcome of the fire control switch test would therefore be documented upon the Report of Thorough Examination ifit was found to be defective (Sections A and B), or required noting as an observation (Section C).*" But the "...additional control features i.e. Fire fighting, Fire recall ..." in Grenfell Tower were the FC switch and the fire recall function. If they had been inspected or tested then at least 3 defects would surely have been found: (i) the blockage with builder's debris in the ground FC switch, (ii) the disconnected FC switch on floor 2, and (iii) the non-functioning fire recall function (cut wires) should all have been recorded on the "Report of Thorough Examination of Lifting Equipment" under "**A. Defects which are or which could become a danger to persons** ...". They were not, and the Inquiry may conclude the proper inference is that these additional control features were not inspected or tested on this occasion.

g) At 6(d) he said the further guidance set out in document GEN001 was followed, but this document has not been produced. Mr Howkins may be able to provide a copy.

h) Also at 6(d) he did not recall any practical effect of procedural reviews and updates upon the procedures he adopted during the relevant period.

i) At §7 he asserts: "*…the lifts I inspected at Grenfell Tower on the 10th April 2017 were in good working order and demonstrated a good standard of maintenance and upkeep. …*". This opinion was contradicted by the long record of complaints from the residents and the history of poor maintenance found by Mr Howkins. Additionally, it does not take into account the extensive lift works which took place in early April 2017, despite which he recorded several defects and made several observations which would not have been expected in the case of well-maintained lifts which had just undergone major works.

19) There is thus no documentary evidence, and only partial and highly questionable witness evidence, to support the proposition that Bureau Veritas engineers inspected the fire controls or tested the FC switch before the fire. The documentary evidence points the other way because of the lack of any mention of the defects referred to above. If the Inquiry finds the witness statement evidence of Mr Lasisi and Mr Arnold of Bureau Veritas relates to checks made after the fire with the benefit of hindsight, then there is likewise no reliable witness evidence to support the assumption.

20) **As to PDERS**

a) There is no documentary record of any inspection or testing of the FC switch or the fire recall function by PDERS' engineers. See the PDERS' Service Visit Reports for both the south lift, referred to therein as "H090", exhibited at MFT/6 {PDR00000047}, and the north lift ("H091"), exhibited at MFT/7 {PD00000041} covering the period from 2014 to the fire. Their service visit reports in fact point the other way:

i) The engineers failed to record observations which, had they so inspected or tested, they are likely to have made. It is unlikely that they would have observed the defects and changes to the location and functionality of the FC switch and then to have made no mention of them. It is much more likely they did not observe them because they did not inspect or test them.

ii) There was no part of the standard form, e.g. a checkbox, to direct nor encourage such inspection or testing of firefighting controls.

b) The service visits were supposed to be monthly, but the records indicate that the whole inspection regime was slackened in the year from Feb'16 to Jan'17 when there were at most only 7 visits (albeit apparently with one purported extra visit to H090 on 18 January 2017):

   i) after 19 February 2016 there were no service visits until 25 May 2016, a gap of over 3 months.

   ii) After 29 June 2016, there were no visits until 18 October 2016, another gap of over 3 months.

c) The service visit reports of the inspections allegedly carried out before the fire appear to reflect extensive use of 'cut and paste' reflecting poorly on the care taken by engineers to inspect and test competently. Taking the PDERS' service visit reports for the south lift (H090) [comparing them for the north lift (H091) {PD00000041} raises the same issue]:

   i) all the items and observations in the reports of Mr Wallis' visit on 9 May 2017 for the south lift (H090) {PDR00000047_0035} appear to have been cut and pasted from the report for the visit on 12 April 2017 {PDR00000047_0034}.

   ii) all but the last ("unit requires pit ladder") of the items and observations in the reports of Mr Wallis' visit on 12 April 2017, for the south lift (H090) {PDR00000047_0034} appear to have been cut and pasted from the report for the visit on 8 March 2017 by Mr Smalley {PDR00000047_0032}.

   iii) all the items and observations in the reports of Mr Smalley's visit on 8 March 2017 {PDR00000047_0032}, appears to have been reported the same day when it was cut and pasted from the purported visit on 18 January 2017 {PDR00000047_0030}

   iv) The report for the visit on 11 February 2017 {PDR00000047_0033}, was not reported until 20 March 2017, when there were no observations for either lift.

   v) There is no explanation for the apparently extra visit to the south lift H090 on 18 January 2017 {PDR00000047_0030}, reported on 18 January 2017. The report was then cut and pasted from the report for the visit on 5 January 2017 {PDR00000047_0029}. There was no report any such purported visit on 18 January 2017 to the north lift (H091).

vi) Much of the report for the visit on 5 January 2017 {PDR00000047_0029}, reported on 5 January 2017 was cut and pasted from the report for the visit in December 2016 {PDR00000047_0028}.

vii) Much of the report for the visit on 16 December 2016 (wrongly entered as 19th) {PDR00000047_0028}, reported on 19 December 2016, was cut and pasted from the report for the visit on 18 October 2016 {PDR00000047_0027}.

viii) The purported visit on 30 November 2016 {PDR00000047_0031}, was not reported until 20 February 2017, when it was cut and pasted from the report for the visit on 5 January 2017 {PDR00000047_0029}, which purportedly took place afterwards.

ix) The report for the visit on 29 June 2016 {PDR00000047_0026}, reported on 11 July 2016 appears to have been cut and pasted from the report for the visit on 25 May 2016 {PDR00000047_0025}.

21) Mr Fallis-Tayor was not in post before the fire. His evidence depends on the documents, on what he is told by engineers and others who were there at the time, as he acknowledges in §3 of his statement of 18 November 2019 {PDR00000050}, and on speculation. The documents do not support the proposition that the fire controls were checked (see above). No weight can properly be attached to his assertions that the engineers "*should have*" (§25) or "*would have*" checked the fire control system and switch or that pre-fire it was functioning properly and in working condition (§34-35). He has produced no documentary evidence to corroborate his assertion at §25 that PDERS engineers attending Grenfell Tower were trained and instructed to and did undertake the test of the FC switch.

22) In §15 of his statement Mr Fallis-Taylor says the Field Management Team carried out periodic checks of the work carried out by the field engineers, and this would occur approximately every 4 months. This is contradicted by item 4 of the task list Directors Meeting Task List of 10 May 2017 {MET00037641_0002}:-

> ...
> 4. Concerns from K&C that there is no form of 'quality checks' in place so as to ensure that the levels of maintenance and general workmanship are at the required levels.
>
> IMMEDIATE ACTION FOR DAVE WATKINS TO CONDUCT 5 QUALITY AUDITS PER MONTH AND THEN TO SHARE THESE AT THE MONHTLY MEETINGS WITH ANTHONY & PAT.

Quality checking is in place, Patrick is very happy with Mark Wallis QA of the team …

23) The GTI has just recently decided to dispense with the oral evidence of Mr Fallis-Taylor and instead to read his statement into the record. The FBU asks the GTI team to reconsider this decision given the partial and self-serving nature of his contentious assertions, all of which are based on hearsay or speculation, not on what he saw, did or heard.

24) Mr Wallis has provided a witness statement of 28 October 2019 {PDR00000036}. The FBU submits this witness statement cannot properly be relied upon to support the proposition that the FC switch was tested and found to be in proper working order before the fire.

a) The service visit records of his only 2 visits before the fire (on 10 April and 9 May) do not record any such testing or inspection of any fire controls (see above). It is incredible that he could have inspected and tested them without noticing and reporting:
   i) the FC switch on the ground floor was stiff and difficult to operate, and then upon rudimentary inspection that it was damaged and blocked with debris (see below),
   ii) the fire recall function was disconnected and, upon rudimentary inspection, that the wires had been cut,
   iii) the temporary FC switch on the second floor was still present and should be removed. In §21 he mistakenly stated there was a decommissioned and non-operational fire control switch on the third floor, whereas it was on floor 2. He did not advise that it should be removed.

b) He said nothing about the very recent works to the lifts seemingly carried out to the south lift (H090) over the previous weekend (1-2 April 2017) and the north lift (H091) on 9 April 2017 – see §5.2 of the minutes of the PDERS meeting with the TMO held on 6 April 2017 {RHO00000003_0187}. No mention was made of these long awaited works in either of Mr Wallis' pre-fire sevice visit reports despite Patrick Barrett's request for a detailed report.

c) Nor did he mention the earth on the ground floor display, which Mr Smalley had reported on 8 March 2017 {PDR00000047_0032} required customer action, nor record whether it had been repaired by the time of his visit on 12 April 2017.

d) He gives no evidence of any written instruction or procedure touching upon the task of checking the FC switch before 9 May 2017, his last purported lift inspection before the fire.

e) At §28 he recalls Phil Edwards, his manager, accompanying him on one of his regular maintenance visits to GT before the fire. But the service visit records make no mention of Mr Edwards being with him on either of his purported 2 such visits before the fire.

25) The FBU have submitted detailed and extensive lines of questioning for these witnesses which are not repeated here but which it is hoped the Inquiry will take into account when assessing the reliability of their witness evidence. If the Inquiry finds the statement of Mr Wallis of PDERS to be unreliable on the issue of any pre-fire testing of the FC switch then, as the FBU submits, there is no reliable evidence to support Mr Howkins' assumption at RHO§487.2.

26) **Not firefighter lifts, so no triangular key which would have lessened the chances of a firefighter having a key of the wrong dimensions** - The lifts in Grenfell Tower were not firefighter lifts, so the FC switch was not operated by a triangular key:

a) The lifts in Grenfell Tower were not firefighter lifts and so could not be used for evacuation, as Dr Lane advised in Appendix L of her Phase 1 report of 24 October 2018 at L6.1.3 {BLAS0000033} and { BLAS0000019_0024}. The type of key to operate the fire control switch (the "FC switch") should have been be in the form of an 'emergency unlocking triangle' as per annex B of EN 81-1:1998 and EN 81-2:1998 the cross section of which is the shape of a triangle {BLAS0000033_0027}.

b) Despite there being no real cost or viability obstacle [RH§306], no-one before the fire specified or advised a FC switch which was fully compliant with BS EN 81-72: 2003 [Please see: RHO§353 re Apex, RHO§416 re B&Y, RHO§417 re KCTMO, RHO§434-5 & §520 re Exova, and the citations from Mr Stokes' correspondence with Matt Smith

of 24 January 2014 {RHO00000003_0028} and from his fire risk assessment of 20 June 2016 cited in Mr Howkins' Lifts Chronology at {RH000000003_0042}].

c) After the fire, experts are agreed "...*The drop key used to operate the fireman's switches proved to be very difficult to operate and may prevent the fireman from gaining use of the lift to fight the fire. We would recommend these are replaced by triangular type keys in accordance with clause 5.8.2 of BS EN 81-72...*" [the WSP Report of August 2018, under "Industry Good Practice" {RH000000004_0132}]. Mr Howkins advises [RHO§601]: "...*Grenfell Tower should have had an 'emergency unlocking triangle ' design of switch, as specified in the relevant standards. The dimensions of these keys are standardised ..., meaning that there is much less chance of a firefighter having a key with the incorrect dimensions. The wide variation of dimensions of the various lift keys tested highlights the importance of the installation of the 'emergency unlocking triangle' design of switches.*" {RHO00000003_0223, emphasis added}.

d) Firefighters were keen to have a drop release key to operate the FC switch, and some sourced them themselves at their own expense. CM Secrett stated that "...these keys get swapped and replaced all the time and they are unidentifiable..." [RHO§577]. Mr Horne's reported, following his examination of the different keys submitted to him, "...There was several millimetres difference in dimension C between the drop keys, Items DER/22, ER/1 and SJG/01 and the drop key Item LJH/67..." [at p.4 of his report of 28 August 2020 {RHO00000004_0318}]. This corroborates CM Secrett's statement that the different drop keys are unidentifiable.

27) **It is not known which drop release key was used by firefighters on the night, and there is no criticism of firefighters sourcing their own drop keys. Firefighters tried repeatedly to operate the FC switch as soon as they got into the tower and thereby repeatedly manipulated it.**

a) Mr Howkins does not criticise CM Secrett or any individual firefighter for sourcing their own drop keys, and the FBU invites the Inquiry to agree with him in this regard: "...Although, as indicated elsewhere in the report, I have general concerns about the inconsistencies in the dimensions of drop keys, I am not in a position to criticise any

individual firefighter who may have sourced a key other than through the POMS system…" [RH§573].

b) It is not known which drop release key was used by the firefighters at Grenfell Tower. It might have been like the one referred to as "LJH/67" later provided by Ff Nuttall, although this is contradicted by CM Secrett's description of turning the key [RHO§597.1]. Or it might have been an ordinary express drop release key like the others labelled "DER/22, ER/1 and SJG/01". The summary table at p.5 of Mr Horne's report of 28 August 2020 {RHO00000004_0319} indicates that only "LJH/67" would not work the FC switch, whereas all of the others could have operated it with force. The force was needed "…*because the panel BJG/74 is in a damaged state with bent side wards*…" [see the asterisk * at the foot of Mr Horne's summary table {RH000000004_0319}. Mr Horne was specifically not there referring to the force needed to clear the blockage caused by builders' debris on the inside of the FC switch (as to which see below).

28) The firefighters tried to operate the FC switch as soon as they got into the tower and repeatedly thereafter, thereby repeatedly manipulating it:

a) CM Secrett tried unsuccessfully at 01:01:35 – see references in the 'FBU's Chronology of Lift Use 21-02-03' attached to these submissions. He could not operate the FC switch using his own drop release key. He pushed the ordinary lift call button. He could not remove his drop release key which felt stiff; he left it in the FC switch. The doors to the south lift opened {RHO00000003_0208, §545}. He and the other firefighters with him then used the south lift to take themselves and some of their equipment to the second floor.
b) Firefighters then took de facto control of the south lift from about 01:02 until 01:37 by blocking the doors with equipment when they were not actually using the lift.
c) Due to the inoperable FC switch, they could not take control of the north lift which remained available for residents to use.
d) CM Gallager tried the FC switch again at 01:34:40 {LFB00032988_0074}, having already found the south lift at ground level full of smoke with its doors open. He could not operate the FC switch using the key already in place {RHO00000003_0210, §547}.

e) He pressed the ordinary call button whereupon the north lift arrived. When its doors opened thick black smoke poured out of the north lift car and shaft whereupon it was decided it would be impossible to use [CM Gallagher's testimony in Phase 1 (Day 39/5-6) on 10 September 2018, and {LFB00032988_0074}].

f) There is no evidence that this north lift was used again by anyone on the night.

g) The south lift was last used by firefighters comprising BA Team 5 who were forced to exit it when it stopped unexpectedly and filled with thick black smoke at about 01:37 at around the 8th floor level [the FBU's Chronology of Lift Use].

h) Ff Nuttall later removed the drop release key which had been left in the FC switch [RHO§548].

29) **Firefighter lifts would have made a difference:**

a) In a high rise residential building (HRRB) it was essential to have working firefighter lifts in the event of fire. Without them the residents were exposed to increased danger and the firefighters were deprived of an essential tool. Dr Lane considers this failure was part of the the culture of non-compliance creating a thread of incorrect information passed from project to project: Dr Lane at §13.6.7-8 of "The Health & Safety File – Main Report", Version 2- Updated 22 October 2020, {BLARP20000001}.

b) The FBU agrees and asks whether, if they had been firefighter lifts, complying with the EU regs:

i) the fire fighters would probably have used the correct emergency unlocking "triangular key" for the fire control switch (the "FC switch")? Having regard to the evidence of Mark Atkinson and the other firefighters, there is no reason to doubt that a standard triangular key would have been available to the firefighters attending Grenfell Tower;

ii) If required to be operated by the correct triangular key, the side wards inside the FC switch would probably not have been damaged and the switch would probably have worked (subject to it having been blocked with builders' debris as to which see below);

iii) the lifts would probably have been brought to the ground floor under the control of firefighters, as they tried to do from the start;

iv) the residents would have been unable to call the lifts from any upper floor and so would not have been exposed to the dangers of using them? {BLAS0000019_0026};

v) the lifts could have been used for firefighting and to assist with rescue and evacuation, including of those with mobility problems or the subjects of fire survival guidance calls (FSGs), until the lifts stopped functioning due to the extreme conditions of the fire [RHO§475].

30) **The firefighters were unable to take control of the lifts because the FC switch was blocked with builders' debris**

a) Mr Howkins has been unable to reach a conclusion as to why the firefighters were unable to take control of the lifts, but has made some observations to assist the Inquiry {RHO00000003_0222}:

> 598. Overall, I do not consider that I can come to a safe conclusion as to why CM Secrett was unable to take control of the lifts on the night. The main possibilities, in my view, are set out below, but I do not consider that I can come to a conclusion as to which of these possibilties is more likely or not.
>
> 598.1. Possibility 1: CM Secrett was unable to take control of the lifts as a lift drop key of
> incorrect dimensions was used which could not operate the switch.
> 598.2. Possibility 2: CM Secrett was unable to take control of the lifts as the fire control
> switch was faulty in some other, unidentified way.
> 598.3. Possibility 3: CM Secrett was unable to take control of the lifts as the fire had affected the lifts in some way, such that the fire control switch did not work.

> 599. I consider that I can make the following observations which may also assist the Inquiry in coming to a conclusion as to why CM Secrett was unable to take control of the lifts, but I do not feel able to come to any conclusion:
>
> 599.1. CM Secrett attempted to take control of the lifts at an early stage of the fire, at approximately 01:01 am (see exhibit CMS/4 to CM Secrett's statement dated 22 November 2018). The lifts continued to operate 'normally' for some time after this (see Section R below).
>
> 599.2. None of the forensic reports or examinations which I have seen disclose any fire-related or smoke-related damage to the fire control switch (BJG/7 4). I consider this of particular relevance when considering possibility 3 set out in the preceding paragraph.

> 599.3. The witness evidence of engineers from Bureau Veritas and PDERS set out earlier in my report is that they tested the fire control switch before the fire and did not identify any faults.

b) We have dealt with RHO§593.3 above.

c) As to Mr Howkins's observation at §599.2, the FBU agree and this would render his "Possibility 3" unlikely. But the FBU asks the Inquiry to consider the effect on the operation of the FC switch of its blockage with builder's debris. This blockage would fall within Mr Howkins' "Possibility 2" above, save for the fact that the blockage has been identified. We deal first with the blockage with builders' debris, but flag now that, in considering "Possibility 2", the FBU also and further asks the Inquiry to take into account the residents' complaints of the lifts breaking down before the fire, and the evidence of faults on the night of the fire (please see below).

31) **Blockage with builders' debris**

a) On 14 June 2017 the FC switch was blocked with building debris, and thus not working. The switch frame arms were found to be jammed by debris on the frame / switch casing. Separately the micro-switch was jammed by what appeared to be wall plaster, grains of which appeared on the work bench after the jam was cleared.

b) The FC switch operated correctly after, but not until, the jam was cleared in the workshop at Deer Park:

i) Its operation was tested on 18 April 2018 {RH000000004_0100}. "… *The faceplate was removed to determine the reason for failing to operate the switch. We discovered that the mechanism was* ***seized and damaged/deformed****. …*" [RH000000004_0108] (see photographs on that page which the FBU would ask be shown during oral opening submissions).

ii) According to the Briefing Note of 1 March 2019 {RH000000004_0223}, following Mr Horne's inspection of the FC switch "BJG/74", applying the standard Express drop key "ER/1" on 15 February 2019, for Operation Northleigh:

"…The MPS visual examination of BJG/74 indicate … **also the micro switch … was jammed**. It appeared to be a wall plaster used during the works.

- During the examination the micro switch became free and the microswitch operated. It is not known what caused the micro switch to jam, but there were plaster grains on the work bench.
- It is considered that the **build up of builders' material on the top of the switch was from the original works** and not caused by the extraction of the switch. This is also my opinion.
- The micro switches installed on BJG/74 … **operated correctly when the jam was cleared** …".

iii) According to Andre Horne's report of 12 November 2019 {RH000000004_0255},

"… *on 15 February 2019 …the* ***switch frame arms of the GF FC switch were found to be jammed*** *… there was* ***some debris*** *evident on the frame which appeared to be dirt/mortar/sand possibly from the construction of the building. It could not be determined if some of this debris had become dislodged during the removal, transportation and storage of the panel to cause the jam or if it had been jammed prior to removal from the building. …* ***After some gentle manipulation by hand it moved freely****. In our opinion, forceful manipulation of a fitting key would have moved the switch frame arms. …* ***The bent side wards and switch frame arm did not cause the jam experienced at the start of the examination***…" {RH000000004_0257}.

c) This debris can be seen on the internal workings of the GF FC switch in photographs 18 & 19 {RH000000004_0234} (which the FBU would also ask be shown during oral opening submissions)..

32) **The blockage explains why the firefighters could not operate the FC switch**

a) At §597.3 of his report of September 2020 Mr Howkins reported *"The fire control switch was jammed with building debris, but with forceful manipulation with a fitting key the fire control switch would probably have worked".* The FBU agrees it was blocked with debris, but asks the Inquiry to reject Mr Howkins' conclusion about the likelihood of it working with forceful manipulation, which is not supported by the evidence set out (and emboldened) in the paragraph above, for the following reasons:

b) The blockage was still present on 15 February 2019 and so was not dislodged by

i) the manipulations of firefighters during the fire, nor by

ii) being tested in situ on 18 April 2018, nor by

iii) being recovered from the tower on 15 July 2018 and removed to Deer Park for testing as "BJG/74" {RH000000004_0323}; nor

iv) when it was first examined on 15 February 2019; nor until

v) the blockage on the frame was cleared by being gently manipulated by hand {RH000000004_0223}.

c) Mr Horne's inability to determine "… *if some of this debris had become dislodged during the removal, transportation and storage of the panel to cause the jam or if it had been jammed prior to removal from the building* …" [please see §13(a)(iii) above] is likely to have been driven by applying the criminal standard of proof 'beyond a reasonable doubt' for Operation Northleigh, whereas the Inquiry determines facts on the balance of probalities.

d) The FBU contends it is likely the firefighters applied reasonable force to operate the FC switch on the night. There is no reason to think otherwise: they were trying to get it to work. If the only obstacle had been the bent side wards, then a standard drop release key, like those labelled ER/1, DER/22 and SJG/01 in Mr Horne's summary table {RH000000004_0319}, would have operated the FC switch. But the blockage would have prevented such a standard drop release key from working, as it did until it was cleared in the workshop on 15 February 2019 (please see §13(a)(i – iv) above).

33) The FBU invites the Inquiry to investigate whether the blockage would have prevented firefighters operating the FC switch on the night whichever type of drop key was used. If so, it is irrelevant whether Crew Manager (CM) Secrett and CM Gallagher and/or Firefighter (Ff) Nuttall used a key like the one later provided by Ff Nuttal (LJH/67), or a standard Express drop release key like DER/22, ER/1 and SJG/01 (please see above): whichever key they used, the FC switch was blocked with builders' debris and could not be turned with the application of reasonable force. If this is right, the blockage is the principal reason why firefighters were unable to take control of the lifts, to prevent residents from using them and to make more use of them on the night, as they repeatedly tried to do.

34) Accordingly the FBU invites the Inquiry not to accept Mr Howkins' conclusion at RHO§597.3: "*...but with forceful manipulation with a fitting key the fire control switch would probably have worked*" but instead to find on the evidence that it probably would not have worked in any event because it was blocked with debris.

35) **The FC switch came to be blocked with builders' debris probably because it was not looked after properly during the main refurbishment works or replaced thereafter.**

a) It may be relevant for the Inquiry to further investigate how the FC switch come to be blocked with builders' debris.

b) There was a lot of builders' dust and debris generated by the works in the vicinity of the ground floor FC switch:

i) Simon Lawrence emailed Claire Williams on 7 October 2015 "*... But bearing in mind we need to use the lift from the ground floor every day to get materials up the Building...*" {RHO00000003_0041}.

ii) Shahid Ahmed stated {IWS00001335} at §151: "*... The lifts used to be out of order almost every week and people used to get stuck in there all the time. ... In the email to Councillor Blakeman and others dated 29 September 2016 (RBK00000185) I referred to the fact the lifts were replaced in 2005. I suggested that the overuse and misuse of the lifts by Rydon during the refurbishment was the cause of the current breakdowns and malfunctions. The lifts were on their last legs despite only being replaced ten years previously… The lifts were malfunctioning and breaking down all the time in the period immediately before the fire….*".

c) Dr Lane's photograph of the ground floor FC switch ("BJG/74") [see Figure L.17 {BLAS0000033_0030}] taken soon after the fire shows that it was secured in place high up in the wall. The photograph is not dated, but she inspected the lifts in GT on 6 October, 1 November, 7-9 November 2017 {BLAS0000033_0001}, and so the photographs pre-date the FC switch being tested in situ on 18 April 2018. The Inquiry may conclude that the FC switch could not have become contaminated with builders' debris if it had been so secured during the works, and thus infer, as the FBU contends,

that it was probably left loose or hanging and thereby exposed to contamination by plaster dust and debris after the temporary FC switch was installed at walkway level on floor 2. How else, the FBU asks, could it have become contaminated by builders' debris?

36) **The lifts were in poor condition and not working properly before the fire:**

a) Residents have given consistent evidence of the lifts constantly breaking down: e.g. Alejandro Serrano and Robert Schwillen, both of Flat 114 on floor 14, stated respectively that the lifts were '*constantly broken*' in {IWS00000853} and that one of the lifts was '*nearly always broken*' {IWS00000854}, both statements read into the record on Day 58 on 15/10/18. We will hear further such evidence during Phase 2.

b) Mr Howins reports that the poor maintenance record of the lifts did not affect the FC switch or the operation of the lifts on the night: RHO§474-6:

§474. *Almost all of the complaints which I have reviewed related to the reliability of the lifts. While there may have been issues with the standard of maintenance generally, I have not seen material evidence which suggests that the maintenance of the fire safety features of the lifts was deficient. RHO00000003*

§475. *Furthermore, the lifts were operational when the LFB initially arrived at Grenfell Tower. Later in the report I consider how the lifts were used during the fire. Therefore, in so far as any reliability issues were reported in relation to both lifts, on the night of the fire both lifts were operational. The lifts did eventually stop functioning but this is likely due to the extreme conditions in Grenfell Tower and not due to maintenance deficiencies. RHO00000003*

§476. *Overall, although there is evidence that there were maintenance deficiencies prior to the fire, they did not, in my view, appear to affect the fire control switch or operation of the lifts, which were the two elements relevant to the lifts' operability on the night of the fire.*

37) **Logged and known faults with the lift on the night:**

a) <u>As to the south lift (H090)</u>:

i) Before the fire there was a problem at **floor 10** as indicated by the pre-fire faults logged for this lift between 00:15 and 00:48 on 14 June 2017 for position 11 (= floor 10) {RHO00000003_0226}.

ii) From 01:14 to 01:16 during the fire, ten faults were logged for H090 at **floor 10** (items 185 to 194) {RH000000004_0113};

i. From 01:16 on the night of the fire until 03:07, no faults were logged for H090

b) As to the north / right hand lift "H091":
   i) Any faults for H091 before 02:32 were not retained by the computer log, which only held the last 200.
   ii) 195 faults were logged for H091 at **floor 10** {RH000000004_0226 - _0228} from 02:32 to 02:33 on the night of the fire giving rise to the following inferences:
      (1) that this lift was stuck near **floor 10** from at latest 02:32;
      (2) that at 02:32 faults at **floor 10** were being logged for H090 at the rate of over 97 per minute (195/2);
   iii) It cannot therefore be properly assumed that H091 was operational until 02:31.

c) As to both lifts:
   i) Inspectors were unable to determine why both lift cars stopped 75mm to 10mm above the **10th floor** {RH000000004_0130}.
   ii) The defects cited above (the disconnected fire alarm recall, the exposed earth wire, the damaged and blocked FC switch)
   iii) This evidence indicates there was a pre-fire problem with the lifts at floor 10. This is precisely where the lifts stopped and became stuck with fatal consequences just before 01:25 (see FBU's Chronology of Lift Use).

38) The FBU invites the Inquiry to consider
   a) whether the poor maintenance record of the lifts reflects unavourably on PDERS' assertions that the FC switch was functioning correctly on the night of the fire, and
   b) whether the poor condition of the lifts contributed to them ceasing to be operational on the night.

39) **Other issues in Module 3 (**apart from the smoke control system, pending further directions from the GTI team**).**

40) **As to Topic 1** (residents' complaints) the FBU welcomes the opportunity afforded the BSRs to explain some of their fire safety concerns before the fire and how they were dealt

with by the TMO. We have cited some of the residents' complaints above in the context of the poor maintenance of the lifts, their frequent breaking down, and their use by builders transporting materials during the refurbishment.

41) **As to Topic 2** (the obligations of the TMO and RBKC under the Regulatory Reform (Fire Safety) Order 2005 (the "FSO") and their compliance with those obligations) the FBU notes the divergent opinions of Mr Todd and Dr Lane and, where they differ, invites the Panel to prefer the opinion of Dr Lane.

42) It is a great shame that careful analysis of the relevant legislation and the guidance given on how to implement it, such as Dr Lane has now provided, was not commissioned and provided by the DCLG soon after the recommendation of Her Honour Frances Kirkham CBE in 2013. This notwithstanding the "... *unnecessary complexity, ...(which)…. opens up the need for interpretation, on an individual responsible person basis; on a premises by premises basis*...." (§6.1.4 of Chapter 1 {BLARP20000023} of her Module 3 report) and "... *the available guidance does not provide a clear explanation of how the legislation applied to blocks of flats, where the fire safety of relevant persons relies upon fire safety measures which cannot be delineated cleanly by means of domestic "versus" non-domestic premises*...." (§6.6.8 ibid).

43) Baron Picklesl, then the Rt. Hon. Eric Pickles MP, should explain to this Inquiry his different conclusion in 2013.

44) The FBU agrees Dr Lane's opinion:

a) that Grenfell Tower was a complex building with a mixture of domestic and non-domestic accommodation, with multiple responsible persons, and over 300 residents [see §1.1.13 of Chapter 1 {BLARP20000023} and of Chapter 8 {BLARP20000027} of her Module 3 report];

b) that "*...Grenfell Tower ... required a comprehensive fire risk assessment process, carried out by a competent fire risk assessor, within a framework of a documented set of fire safety arrangements, including a documented and comprehensive emergency plan*". [see §1.1.36 of Chapter 8]

c) that, while recognising there was a body of opinion that considered them to fall outside the scope of the FSO, the external walls of Grenfell Tower were a collective protection measure under the FSO (§6.4.11 & §6.6.11 ibid + Chapter 10, {BLARP20000032};

d) that notwithstanding compartmentation between the structure and exterior of Grenfell Tower and the flats was a critical fire protection measure for the relevant persons, it fell outside the remit of both enforcement authorities (RBKC and LFEPA) under the terms of the protocol they signed on 20 February 2012 so that the fire safety implications of the rainscreen cladding system were not addressed (§3.3.24-33 of Chapter 1) by those authorities.

e) that it behoved responsible persons and their safety assistants to have considered HM "Sleeping accommodation" guide fully, not just the LGA Guide in isolation, nor as a primary reference source (see §5.1.24 of Chapter 1).

f) That RBKC's fire safety risk management system for its huge property portfolio of 9,476 properties (see §8.4.6 of Chapter 1) appears to have been woefully underfunded. Whereas adequate resources were required to fund RBKC's fire risk management system, fire risk assessments (FRAs) borough wide cost £1,226 per month for the period ending 31 July 2014 (§8.4.57 &ff Figs. 8-13 and 8-14 of Chapter 1). And "FRA works" cost £200,000 in the year 2016-17 and £136,350 in 2017-18. Dr Lane could not find a comprehensive and clear budgeting process, for all aspects of the KCTMO fire risk management system, nor understand how KCTMO communicated to RBKC the resources that were required, each year, for KCTMO to adequately implement their fire risk management system, and thereby comply with the FSO (§8.4.68-69, ibid).

g) That the TMO's, and so also RBKC's, fire safety management system was woefully under-resourced: the health and safety team comprised, top down, the Chief Executive (Robert Black), who appointed Anthony Parkes to June 2015, then Barbara Matthews as the Executive Director of Financial Services & ICT to take day to day responsibility, and Janice Wray as "Health, Safety and Facilities Manager" (§8.4.91 of Chapter 1). Dr Lane found no evidence of KCTMO assigning any persons as specific fire safety managers of individual buildings or groups of buildings (§8.4.98 ibid).

h) Against this background it is no surprise that Mr Stokes submitted the lowest bid of all 5 tenderers for the role of fire risk assessor or that the TMO failed in their primary duty to monitor and review their fire risk assessment programme and assure themselves it

was producing suitable and sufficient assessments of risk for their premises [§7.6.86 and §16.1.20 of Chapter 8].

i) That the Local Government Association: Fire Safety in purpose-built blocks of flats (LGA Guide) 2012 (LGA guide) "*...significantly downplays, for block of flats, the importance of the planning and recording of fire safety arrangements, as well as the need to clearly communicate organisational arrangements, as part of the duties the responsible person has under the RR(FS)0...*" (§3.5.14 of Chapter 2 {BLARP20000024}. If the Panel agrees this is a valid criticism it may assist in deciding whether to prefer Dr Lane's opinion or Mr Todd's where they differ.

j) That both Mr Stokes's fire risk assessments for Grenfell Tower and the TMO's responses to them, showed a lack of rigour without top-down monitoring [§1.1.48 &ff of Chapter 8 {BLARP20000027}]. For example, at no time between 2010 and 2017 did any employee correct Mr Stokes statement in his fire risk assessment report that a general evacuation of Grenfell Tower would be arranged in the event of a fire by KCTMO employees [§1.1.57 ibid].

k) That several correct and significant interventions by LFB and residents were seen as a hurdle to get over, a paperwork problem to close out, and the potential risk to life was not evaluated and that Mr Stokes contributed to a culture of ignoring warnings from these valid stakeholders, so called interested parties as defined in PAS 7:2013 [§1.1.76-78 ibid].

l) He consistently under-assessed the overall risk rating of Grenfell Tower as "tolerable", failed to obtain information and documents which he needed (including a fire strategy document for GT, the occupancy profile, information relating to the FC switch and the type of lifts installed), failed to record that he was missing information for example regarding the occupancy profile (Section 11), or the emergency plan for Grenfell Tower (Section 16) or about KCTMO's overall fire risk management system (Section 15). Yet the evidence shows, he was incorrect in his assumptions about these subjects [§9.10.37 – 39, §9.11.20, §10.1.4 and §10.2.4].

m) That he erroneously reported: "...Both the lifts in this building are evacuation/ firefighting lifts and could be used in the evacuation of any disabled residents from the building." [§10.2.4 of Chapter 8, and Chapter 9] and mis-stated the TMO's evacuation strategy for Grenfell Tower, relying on a fire alarm in the common areas of Grenfell Tower which did not exist from floors 4 to 20 and non-existent employees to arrange an evacuation. The TMO failed to correct his mistakes [§10.7.7 – 47 and §15.3.10].

He failed to follow up on the need for evacuation drills [§15.3.30 & ff, §16.1.4, §16.1.15].

n) That there were no documented arrangements made by KCTMO to confirm that their employees would arrange for a general evacuation of any high rise residential building and KCTMO made no such arrangements for Grenfell Tower [§16.4.3-6].

o) That Mr Stokes substantially failed to adequately consider the arrangements for the safe evacuation of people identified as being especially at risk, particularly those with vulnerabilities relevant to a fire event [§16.5.33].

p) That he consistently failed to advise on the need for a wet rising main [§12.6.11].

q) That Mr Stokes appears to have invented a series of postnominals to include in his fire risk assessments, created misleading communications for his clients, about his training and qualifications and implied he was included in the IFE register of fire risk assessors, which he was not [§6.5.37, §6.5.33 and §6.5.39].

r) That there is "…*currently no formal designation equivalent to chartership, for fire risk assessors, and this is a concern…*" notwithstanding they must be competent [§1.1.91, §2.5.2 and §4.2.1 ibid]. Dr Lane was unable to find any guidance like the Fire Risk Assessment Competency Council's "Choosing a Competent Fire Risk Assessor" is dated 2013 version 1, {HOM00025548}, that would have been in place in 2010 when KCTMO first appointed Mr Stokes [§6.5.29 ibid].

s) Once again, the FBU makes the point that industries cannot be trusted to regulate themselves. After the Lakanal House fire recommendations were entrusted to the Fire Sector Federation whose efforts failed to solve the problem of ensuring adequate training qualification and competency for fire risk assessors of complex buildings. This was a factor in the Oldham Street fire also, leading to the Senior Coroner Meadows recommending: "… *that the Secretary of State for the Home Department considers measures to ensure that:*

> *a) fire risk assessors are adequately trained and qualified so as to be competent in the role, and*
>
> *b) the responsible person has the means to verify the competence of any person holding themselves out to be a fire risk assessor.*"

t) That creating "…a *well-structured definition of competence, and associated qualifications, training and experience, as well as professionalising the role of fire risk assessor, would in my opinion be an appropriate focus for recommendations from Phase 2 of the Inquiry…*" [§6.5.43].

45) The FBU invites the Panel to prefer Dr Lane's assessment of the TMO's fire safety risk management system and the inadequacy of the fire risk assessments of Mr Stokes to that of Mr Todd where they differ. In this context, the Panel may find that Mr Todd's statement to the police provided an unreliable assessment. His conclusion {§2.19 of his police statement of March 2018 {MET00012981}: "*…There is evidence that Mr Stokes had a good understanding of all relevant legislation and guidance and that he keeps his knowledge up to date (e.g. in relation to lessons learned from relevant serious fires). My further opinion is that, though there are minor errors or deficiencies in the documented FRA, the 2016 FRA for Grenfell Tower was carried out competently…*" cannot survive Dr Lane's more thorough scrutiny and preferable understanding of the leglisation and the relevant guidance.

46) The other side of the same coin is that Mr Stokes was appointed without tender and was allowed to work largely unsupervised and unsupported by a woefully inadequate fire risk management system.

47) **As to Topic 3, in addition to our submissions on the lifts (above)** the FBU agrees Mr Hancox' report of 1 October 2019 { RHX00000012] about **the installation of a new gas riser in the stairwell**. The FBU hopes the Inquiry will investigate how and why the possibility of running the new gas riser in the same place as the old riser was discounted in discussions between tRIIO and TMO [§317]. It bears the appearance of a shameful disregard of the safety of residents to take the easy option of running it up the sole means of escape thereby further reducing the already minimal and confined space and introducing combustible material (timber and gas) to a protected area. Mr Hancox' conclusion is that Cadent should have refused to replace the gas riser and offered compensation to the residents instead [§446]. The FBU hopes the Inquiry will investigate the question whether the decision to place the gas riser in the single means of escape was justifiable on any ground other than keeping down costs?

Martin Seaward, Counsel for the FBU

19 March 2021

IN THE GRENFELL TOWER INQUIRY

Chaired by
Sir MARTIN MOORE-BICK

Sitting with fellow Panel members
Thouria Istephan and **Ali Akbor** OBE

Advised and assisted by Assessors, currently:
Joe Montgomery CB,
Professor David Nethercot OBE, and
John Mothersole,

FBU's Opening Statement for Module 3 of Phase 2 of the GTI

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